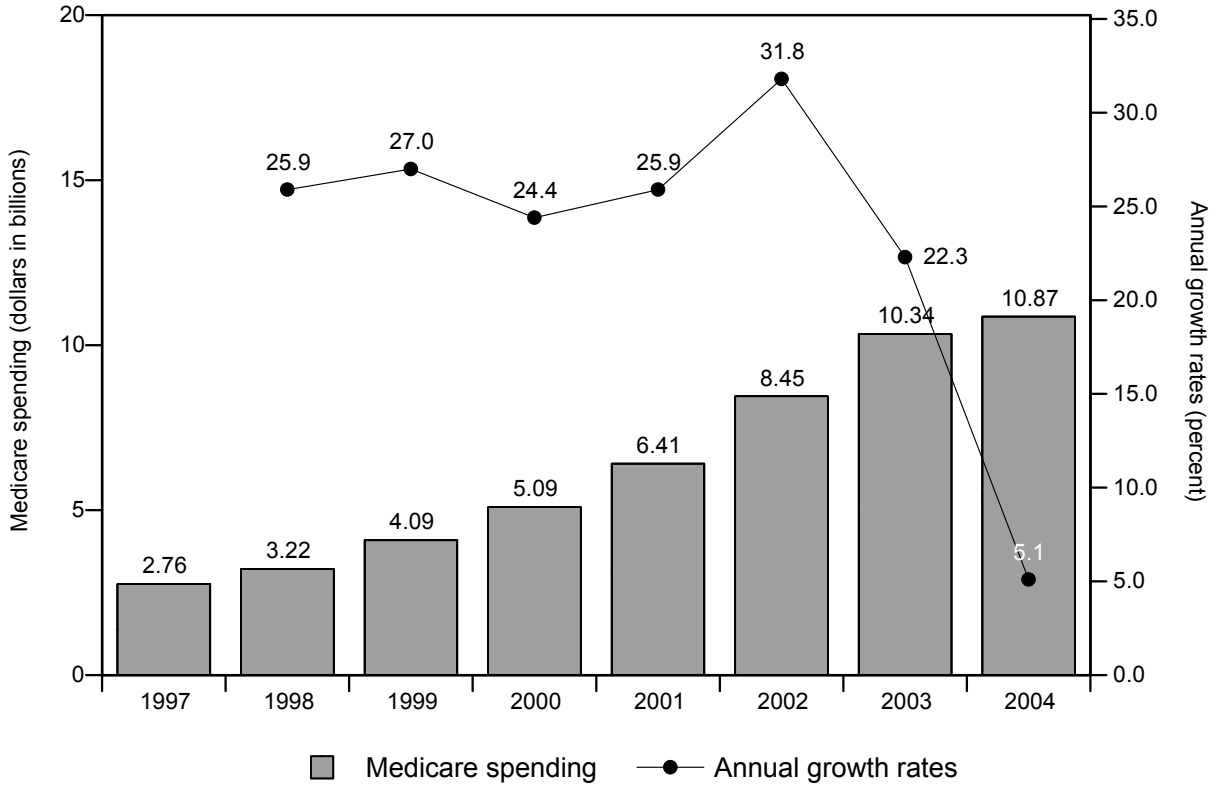
SECTION 11

Drugs

Chart 11-1. Medicare spending and annual growth rates for Part B drugs



Source: MedPAC analysis of unpublished CMS data.

- MedPAC estimates that spending for Part B drugs totaled $10.9 billion in 2004, an increase of 5.1 percent over 2003. This sum represents about 4 percent of total Medicare spending.

- These totals do not include drugs provided through outpatient departments of hospitals or for end-stage renal disease patients in dialysis facilities. MedPAC estimates that in 2004, freestanding and hospital-based dialysis facilities alone billed Medicare an additional $3.2 billion for drugs.

- The primary reason for growth in these expenditures is the increased volume of drugs used and the substitution of newer and more expensive medications for older therapies.

- In 2005, CMS changed its reimbursement rate to 106 percent of the average sales price (ASP). Preliminary estimates by CMS indicate that spending for Part B drugs in 2005 declined by 3 percent.

Chart 11-2. Top 10 drugs covered by Medicare Part B, by share of expenditures, 2004

Drug name	Clinical indications	Competition	FDA approval date	Percent of spending
Non-ESRD erythropoietin	Anemia	Multisource biological	1989	9.0%
Darbepoetin alfa	Anemia	Sole source	2001	7.9
Rituximab	Non-Hodgkins lymphoma	Sole source biological	1997	5.5
Ipratropium bromide	Asthma	Generic	1993	5.4
Leuprolide acetate suspension	Prostate cancer	Multisource	1985	5.3
Infliximab	Rheumatoid arthritis, Crohn's disease	Sole source biological	1999	5.0
Pegfilgrastim	Cancer	Sole source	2002	4.6
Albuterol	Asthma	Generic	1982	3.7
Goserelin acetate implant	Prostate cancer	Sole source	1989	3.4
Unclassified new drugs	Various	N/A	4/1/03 to present	3.0

Note: ESRD (end-stage renal disease), FDA (Food and Drug Administration), N/A (not available).
*Drugs that the FDA has approved since April 1, 2003 are categorized as unclassified new drugs.

Source: MedPAC analysis of 2004 Medicare claims data from CMS and unpublished FDA data.

- Medicare covers about 550 outpatient drugs, but spending is very concentrated. The top 10 drugs account for about 53 percent of all Part B spending.
- Spending for new drugs dominates the list. Of the top 10 drugs covered by Medicare in 2003, four received Food and Drug Administration approval in 1996 or later. In addition, spending on injectables too new to have received their own payment codes accounted for 3 percent of Part B drug spending.
- Treatment for cancer dominates the list—16 of the top 20 drugs treat cancer or the side effects associated with chemotherapy.

Chart 11-3. Part D enrollment and other sources of drug coverage in early 2006

	Millions enrolled as of					
	1/13/2006	2/11/2006	3/13/2006	4/18/2006	5/7/2006	6/11/2006
Enrollment that leads to Medicare program spending:						
Voluntary enrollees in stand-alone PDPs	3.6	4.9	6.4	8.1	8.9	10.4
Enrollees in MA–PDs (including some duals)	5.1	5.3	5.7	5.8	5.9	6.0
Individuals dually eligible for Medicare and Medicaid and auto-enrolled in Part D plans	5.6	5.7	5.8	5.8	5.9	6.1
Individuals covered by Medicare RDS	6.4	6.4	6.2	6.8	6.9	6.9
Subtotal	20.6	22.3	24.0	26.5	27.6	29.4
Enrollment that does not lead to Medicare program spending*:						
Estimated federal retirees in FEHB and Tricare	3.1	3.1	3.5	3.5	3.5	3.5
Total	23.8	25.4	27.6	30.0	31.1	32.8

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), RDS (retiree drug subsidy), FEHB (Federal Employees Health Benefits program). Tricare is the health program for military retirees and their dependents. For calendar year 2006, CMS projects that an average of 43.1 million beneficiaries will be enrolled in Medicare Parts A and/or B. Columns may not sum due to rounding.
*In addition, CMS estimates that 5.4 million Medicare beneficiaries have drug coverage of equal or greater value to Part D benefits through the Department of Veterans Affairs, Indian Health Service, former employers that do not receive Medicare's retiree drug subsidy, current employers, or state pharmaceutical assistance programs.

Source: CMS press releases dated as shown above.

- As of June 2006, CMS estimated that 29.4 million of the 43 million Medicare beneficiaries (68 percent) were either signed up for Part D plans or had prescription drug coverage through employer-sponsored coverage under Medicare's retiree drug subsidy (RDS). (If an employer agrees to provide primary drug coverage to its retirees with an average benefit value that is equal or greater in value to Part D (called creditable coverage), Medicare provides the employer with a tax-free subsidy for 28 percent of each eligible individual's drug costs that fall within a specified range of spending.)
- Voluntary enrollees in stand-alone drug plans numbered 10.4 million, or 24 percent of all Medicare beneficiaries. Individuals who are dually eligible for Medicare and Medicaid and enrollees in Medicare Advantage–Prescription Drug plans numbered 6.0 million and 6.1 million, respectively; each group is 14 percent of all beneficiaries. Individuals whose employers received Medicare's RDS numbered 6.9 million, or 16 percent. Those four groups of beneficiaries directly affect Medicare program spending.
- Other Medicare beneficiaries have creditable drug coverage, but that coverage does not affect Medicare program spending. For example, 3.5 million beneficiaries (8 percent) were federal retirees who receive drug coverage through the Federal Employees Health Benefits program or Tricare. Another 5.4 million others (12 percent) (not shown) had prescription drug coverage through the Department of Veterans Affairs, Indian Health Service, other former employers that are not a part of Medicare's RDS, current employers because the individual is still an active worker, or state pharmaceutical assistance programs.

Chart 11-4. Characteristics of Medicare PDPs in 2006

	All types of benefits	Basic benefits: Defined standard	Basic benefits: Actuarially equivalent	Enhanced benefits
Total number of plans	1,429	132	689	608
Distribution of plans				
Plan type	100%	9%	48%	43%
Type of deductible				
Zero	58	N/A	18	40
Reduced	8	N/A	5	3
$250	34	9	25	0
Cost-sharing structure before the initial coverage limit				
Uses 25% coinsurance	9	9	0	0
Uses tiered cost sharing	91	N/A	48	43
Copays	21	N/A	8	13
Coinsurance	3	N/A	2	0
Combination	67	N/A	38	30
Coverage in the gap				
Generics	13	N/A	0	13
Generics and brands	2	N/A	0	2
None	85	N/A	48	27
Offers mail-order pharmacy services	91	8	43	40

Note: PDP (prescription drug plan), N/A (not applicable). Percentages are not weighted by plan enrollment. The PDPs described here exclude those offered in U.S. territories. Benefits labeled actuarially equivalent to Part D's standard benefit include what CMS calls "actuarially equivalent standard" and "basic alternative" benefits. Plans with "gap coverage" include some benefits in the range of beneficiary drug spending above the standard benefit's initial coverage limit and below its out-of-pocket threshold. Part D's defined standard benefit requires the enrollee to pay 100 percent coinsurance in this coverage gap.

Source: MedPAC analysis of CMS plan benefit package and landscape data.

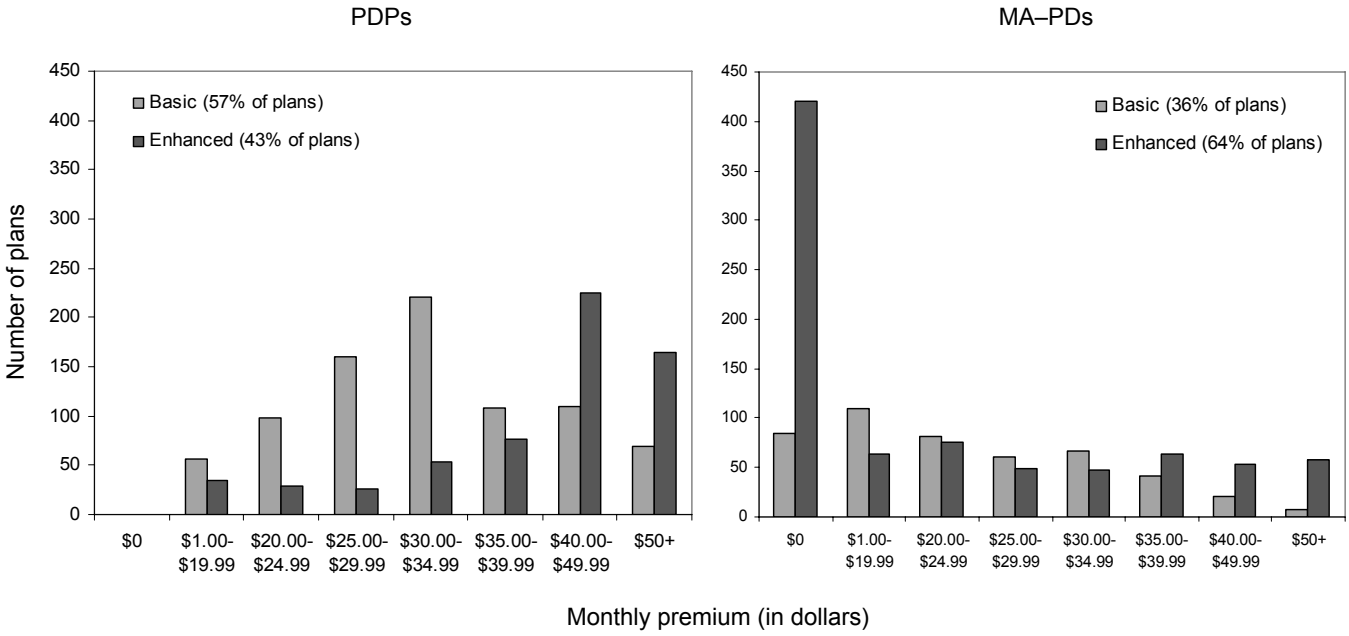
- Among all 1,429 prescription drug plans (PDPs), 57 percent provide basic benefits—either Part D's standard benefit design (9 percent) or a benefit that is actuarially equivalent to the standard benefit (48 percent). The remaining plans are enhanced (43 percent); they include basic benefits and some supplemental coverage.

- Fifty-eight percent of the 1,429 PDPs do not charge a deductible, 34 percent use the standard benefit's $250 deductible, and the remaining 8 percent use deductibles that are less than $250. No enhanced plans use the standard benefit's $250 deductible, and many actuarially equivalent plans charge no deductible either. A plan could charge no deductible yet maintain actuarial equivalence to the standard benefit by charging higher cost sharing or lowering the benefit's initial coverage limit.

- Most plans (91 percent) use cost-sharing tiers rather than the defined standard benefit's flat 25 percent coinsurance. However, 67 percent of all PDPs use a combination of copays for some (usually lower price) tiers and coinsurance (typically for specialty drugs placed on higher price tiers).

- Relatively few PDPs offer any coverage in the standard benefit's coverage gap.

Chart 11-5. Distribution of PDP and MA–PD premiums for basic and enhanced plans in 2006



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Distributions are not weighted by beneficiary enrollment. Total number of PDPs is 1,429, which excludes plans offered in U.S. territories. Total number of MA–PDs is 1,303, which excludes demonstration programs, 1876 cost plans, and plans offered in U.S. territories. MA–PD enrollees must pay any other Medicare Advantage premiums in order to obtain Part D prescription drug coverage. Benefits labeled basic include Part D's standard benefit design as well as benefits that are actuarially equivalent to standard benefits. Enhanced plans include supplemental coverage.

Source: MedPAC analysis of CMS plan benefit package and landscape data.

- Among all basic prescription drug plans (PDPs) (defined standard benefits and those that are actuarially equivalent), the simple average monthly premium is $33. CMS officials have noted that beneficiary premiums are expected to average $23 per month. The reason for this difference is that the $23 figure is weighted by Part D enrollment.

- At the median, premiums for enhanced PDPs run about $10 more per month than premiums for basic PDPs. Within each category of basic and enhanced plans, there is quite a bit of variation among premiums. Some enhanced benefits cost less than $20 per month in certain regions, while other basic plans cost more than $50 per month.

- Medicare Advantage–Prescription Drug plans (MA–PDs) tend to have lower premiums for their drug benefits than PDPs. More than 500 MA–PDs (nearly 40 percent) charge no additional premium for Part D coverage beyond what the plan charges for Parts A and B services.

Chart 11-6. PDPs offered in 2006 by organizations with at least one nationwide plan

Organization	Plan name	Regions in which plan is offered	Plans qualifying for auto-enrollment	Type of benefit	Range of monthly premiums	Deductible	Cost sharing by tier at in-network preferred pharmacies	Gap coverage
Aetna	**Aetna Medicare Rx Essentials**	**34**	**6**	**Actuarially equivalent**	**$28–$39**	**$250**	**$5/$25**	None
	Aetna Medicare Rx Plus	**34**	**0**	**Enhanced**	**37–50**	**0**	**$7/$35**	Generics
	Aetna Medicare Rx Premier	**34**	**0**	**Enhanced**	**52–67**	**0**	**$2/$20/$40**	Generics
Cigna	CIGNATURE Rx Value Plan	34	7	Actuarially equivalent	30–37	250	$4/$20/$40	None
	CIGNATURE Rx Plus Plan	34	0	Enhanced	40–42	0	$5/$30/$50	None
	CIGNATURE Rx Complete Plan	34	0	Enhanced	43–51	0	$5/$30/$50	Generics
Coventry	**AdvantraRx Value**	**34**	**0**	**Enhanced**	**18–25**	**0**	**$10–$15/$36–$60**	None
	AdvantraRx Premier	**34**	**0**	**Enhanced**	**29–38**	**0**	**$5–$10/$20–$40/ $50–$70**	None
	AdvantraRx Premier Plus	**34**	**0**	**Actuarially equivalent**	**40–50**	**0**	**$5/$20–$40/$54–$70**	None
Medco	YOURx Plan	34	19	Actuarially equivalent	27–36	250	$4/$17/75%/25%	None
MemberHealth	**Community Care Rx Basic**	**34**	**23**	**Actuarially equivalent**	**26–33**	**250**	**0%/25%/45%**	None
	Community Care Rx Choice	**34**	**0**	**Actuarially equivalent**	**34–41**	**250**	**$4/$20/$40**	None
	Community Care Rx Gold	**34**	**0**	**Enhanced**	**38–45**	**100**	**$4/$25/$50**	None
PacifiCare	PacifiCare Saver	34	31	Actuarially equivalent	19–35	0	$8/$22/$47–$53/33%	None
	PacifiCare Select	34	2	Actuarially equivalent	30–49	0	$8/$22/$56–$73/33%	None
	PacifiCare Comprehensive Plan	2	0	Enhanced	37–41	0	$8/$22/$53–$54/33%	Generics
	PacifiCare Complete Plan	32	0	Enhanced	34–55	0	$8/$22/$22–$54/ $53/33%/33%	Generics

Organization	Plan name	Regions in which plan is offered	Plans qualifying for auto-enrollment	Type of benefit	Range of monthly premiums	Deductible	Cost sharing by tier at in-network preferred pharmacies	Gap coverage
Silverscript	**SilverScript**	**34**	**27**	**Actuarially equivalent**	**$24–33**	**$250**	**$7–$9/25%/25%**	**None**
	SilverScript Plus	**34**	**0**	**Actuarially equivalent**	**49–63**	**100**	**$7–$8/$22–$25/ $60–$62/25%**	**None**
Unicare	Medicare Rx Rewards	34	34	Actuarially equivalent	17–31	250	$5/$25/25%/25%	None
	Medicare Rx Rewards Plus	33	0	Enhanced	26–39	0	$10/$30/25%/25%	None
	Medicare Rx Rewards Premier	33	0	Enhanced	35–52	0	$10/$30/$60/30%/ 30%	Generics
United	**AARP Medicare Rx**	**34**	**33**	**Actuarially equivalent**	**23–30**	**0**	**$5/$28/$55–$56/25%**	**None**
	United Health Rx	**4**	**4**	**Actuarially equivalent**	**21–23**	**50**	**$7/$23/$54/25%**	**None**
	United Medicare MedAdvance	**34**	**28**	**Actuarially equivalent**	**27–32**	**0**	**$10/$23/$52–$55/ 25%**	**None**
WellCare	WellCare Signature	34	33	Actuarially equivalent	17–33	0	$0/$0/$62–$73/ $62–$73/30%–33%	None
	WellCare Complete	34	0	Enhanced	33–51	0	$0/$0/$15/$50/30%	None
	WellCare Premier	34	0	Enhanced	35–54	0	$0/$0/$30/$60/30%	None

Note: PDP (prescription drug plan). Benefits labeled as actuarially equivalent to Part D's standard benefit include actuarially equivalent standard and basic alternative benefits. Plans that "qualify for auto-enrollment" have premiums that are at or below threshold values calculated by CMS for each PDP region. Plans with "gap coverage" include some benefits in the range of beneficiary drug spending above the standard benefit's initial coverage limit and below its out-of-pocket threshold. Part D's defined standard benefit requires the enrollee to pay 100 percent coinsurance in this coverage gap. The PDPs described here exclude those offered in U.S. territories.

Source: MedPAC analysis of CMS plan benefit package and landscape data.

- Ten organizations have at least one plan in all 34 of the prescription drug plan (PDP) regions across the nation (excluding U.S. territories). The offerings of these 10 organizations account for nearly 900 of the 1,429 PDPs available across the 34 regions.

- None of these organizations offers Part D's defined standard benefit design for 2006. Instead, most use tiered copays or a combination of copays and coinsurance, and keep the standard benefit's $2,250 initial coverage limit. Many of the plans have equivalent actuarial values to the standard benefit, but charge no deductible or a deductible lower than the standard benefit's $250. While most of these sponsoring organizations chose to offer one or more enhanced plans, fewer than half of those enhanced plans provide coverage in the standard benefit's coverage gap.

Chart 11-7. "Near-national" organizations with 30 or more PDPs among the 34 regions

Organization	Plan name	Regions in which plan is offered	Number qualifying for auto-enrollment	Type of benefit	Range of monthly premiums	Deductible	Cost sharing by tier at in-network preferred pharmacies	Gap coverage
American Progressive	Prescription Pathway Bronze	1	1	Defined standard	$25	$250	25%	None
	Prescription Pathway Silver	8	0	Actuarially equivalent	34–41	250	$5–$6/$27–$28/25%	None
	Prescription Pathway Gold	8	0	Enhanced	46–52	0	$5–$6/$27–$28/25%	None
	Prescription Pathway Platinum	7	0	Enhanced	64–69	0	$6/$24/$40/25%	None
Marquette	Prescription Pathway Silver	22	0	Actuarially equivalent	34–43	250	$4/$29/25%	None
	Prescription Pathway Gold	22	0	Enhanced	46–54	0	$4/$29/25%	None
	Prescription Pathway Platinum	22	0	Enhanced	62–71	0	$4/$26/$42/25%	None
Pennsylvania Life	Prescription Pathway Bronze	31	25	Defined standard	24–34	250	25%	None
	Prescription Pathway Silver	31	0	Actuarially equivalent	34–43	250	$5/$28/25%	None
	Prescription Pathway Gold	31	0	Enhanced	46–54	0	$5/$28/25%	None
Humana	Humana PDP Standard	31	30	Defined standard	2–18	250	25%	None
	Humana PDP Enhanced	31	0	Enhanced	5–25	0	$7/$30/$60/25%	None
	Humana PDP Complete	31	0	Enhanced	39–73	0	$7/$30/$60/25%	Generics, brands
Sterling	Sterling Prescription Drug Plan	32	0	Actuarially equivalent	49–61	100	$10/$22–$28/ 40%–50%/25%	None
United American	UA Medicare Part D Prescription Drug Coverage	31	2	Actuarially equivalent	30–41	0	$9/$30/$60/33%	None

Note: PDP (prescription drug plan). Benefits labeled as actuarially equivalent to Part D's standard benefit include actuarially equivalent standard and basic alternative benefits. Plans that "qualify for auto-enrollment" have premiums that are at or below threshold values calculated by CMS for each PDP region. Plans with "gap coverage" include some benefits in the range of beneficiary drug spending above the standard benefit's initial coverage limit and below its out-of-pocket threshold. Part D's defined standard benefit requires the enrollee to pay 100 percent coinsurance in this coverage gap. The PDPs described here exclude those offered in U.S. territories.

Source: MedPAC analysis of CMS plan benefit package and landscape data.

- While they are not national plans, another 6 organizations are major participants in Part D—they offer 30 or more prescription drug plans (PDPs) across the 34 regions. A few of these organizations offer a larger total number of plans than do some of the 10 organizations with nationwide offerings. Combined, these "near-national" entities contribute more than 300 of the 1,429 PDPs available across the 34 regions.
- For 2006, several of these organizations offer Part D's defined standard benefit.

Chart 11-8. Premiums and cost-sharing requirements among PDPs in 2006

	Basic benefits		
	Defined Standard*	Actuarially equivalent	Enhanced benefits
Monthly premium			
Minimum	$2	$14	$5
Maximum	85	63	105
Median	28	32	44
Mean	26	35	43
Deductible			
Minimum	250	0	0
Maximum	250	250	150
Median	250	250	0
Median cost sharing for:			
Plans with generic/brand tier structure			
Generic copay	N/A	5	7
Brand copay	N/A	28	30
Specialty tier coinsurance (where applicable)	N/A	25%	25%
Plans with generic/preferred brand/nonpreferred brand tier structure			
Generic copay	N/A	$7	$5
Preferred brand copay	N/A	22	26
Nonpreferred brand copay	N/A	55	50
Specialty tier coinsurance (where applicable)	N/A	25%	30%

Note: PDP (prescription drug plan), N/A (not applicable). Values do not reflect plan enrollment. The PDPs described here exclude plans offered in U.S. territories. Cost sharing is for median cost sharing among plans that use tiered cost sharing before the initial coverage limit. Benefits labeled actuarially equivalent to Part D's standard benefit include actuarially equivalent standard and basic alternative benefits.
*The defined standard benefit charges 25 percent coinsurance between a $250 deductible (in 2006) and the benefit's initial coverage limit of $2,250 in covered drug spending (in 2006).

Source: MedPAC analysis of CMS plan benefit package and landscape data.

- Across all types of prescription drug plan (PDP) benefits offered among the 1,429 plans (including both basic and enhanced packages), the lowest-premium plan is a defined standard benefit at a cost of just under $2 per month, while the higher premium plan provides enhanced coverage for about $105 per month.

- Plans that use tiered cost sharing tend to charge fixed-dollar copays rather than a percentage coinsurance of the prescription's price. Among plans that use a generic/brand tier structure, median copays for generic drugs are $5 to $7, and those for brand name drugs are $28 to $30. Plans that distinguish between preferred and nonpreferred brand name drugs charge copays of $7 to $5 for generics, $22 to $26 for preferred brand name drugs, and $55 to $50 for nonpreferred brand name drugs. Many plans use a separate tier for higher cost specialty drugs, such as biologics. PDPs that use a specialty tier tend to charge 25 percent to 30 percent coinsurance. Based on CMS guidance, plan enrollees may not appeal payment of a lower tier's cost-sharing requirement for such specialty drugs.

Chart 11-9. Geographic distribution of PDPs in 2006

PDP region	States in the region	Number of PDPs: Total	Number of PDPs: That qualify for auto-enrollment	Number of PDPs: With a monthly premium ≤ $20	Mean premium for: Basic benefits	Mean premium for: Enhanced benefits
1	ME, NH	41	14	1	$35	$44
2	CT, MA, RI, VT	44	11	4	31	42
3	NY	46	15	6	32	37
4	NJ	44	14	4	32	41
5	DC, DE, MD	47	15	3	33	45
6	PA, WV	52	15	2	34	45
7	VA	41	16	2	34	44
8	NC	38	13	2	37	46
9	SC	45	16	1	35	47
10	GA	42	14	1	34	43
11	FL	43	6	4	34	47
12	AL, TN	41	9	1	35	48
13	MI	40	14	1	34	43
14	OH	43	10	3	33	42
15	IN, KY	42	13	1	36	46
16	WI	45	14	4	31	41
17	IL	42	15	1	32	43
18	MO	41	10	2	34	43
19	AR	40	13	2	35	46
20	MS	38	12	2	36	47
21	LA	39	11	1	38	48
22	TX	47	16	2	33	44
23	OK	42	12	2	36	46
24	KS	40	11	2	34	42
25	IA, MN, MT, ND, NE, SD, WY	41	14	3	32	44
26	NM	43	8	6	29	41
27	CO	43	10	3	32	41
28	AZ	43	6	4	31	40
29	NV	44	7	3	30	40
30	OR, WA	45	15	5	31	41
31	ID, UT	44	14	3	34	44
32	CA	47	10	6	28	38
33	HI	29	8	3	31	37
34	AK	27	8	0	34	41
Total		1,429	409	90	33	43

Note: PDP (prescription drug plan). Mean values are not weighted by plan enrollment. The PDPs described here exclude plans offered in U.S. territories. Benefits labeled basic include Part D's standard benefit design as well as benefits that are actuarially equivalent to standard benefits. Enhanced plans include supplemental coverage. Plans that "qualify for auto-enrollment" have premiums that are at or below threshold values calculated by CMS for each PDP region.

Source: MedPAC analysis of CMS plan benefit package and landscape data.

- For 2006, all regions of the country experienced strong plan entry among stand-alone PDPs. Every region has at least 27 PDPs offering Part D coverage and the median number of plans per region is 43. Medicare beneficiaries who qualify to receive Part D's low-income subsidies have a broad choice of PDPs available. All regions but Alaska have at least one PDP available with a monthly premium of $20 or less.

Chart 11-10. Characteristics of MA–PDs' drug benefits in 2006

	All types of benefits	Basic benefits		Enhanced benefits
		Defined standard	Actuarially equivalent	
Total number of plans	1,303	96	376	831
Distribution of plans (in percent):				
Plan type	100%	7%	29%	64%
Type of organization				
Local HMO	66	4	18	43
Local PPO	21	1	8	12
PFFS	10	1	2	7
Regional PPO	4	1	1	2
Type of deductible				
Zero	80	N/A	18	62
Reduced	3	N/A	2	1
$250	17	7	8	1
Cost-sharing structure before the initial coverage limit				
Uses 25% coinsurance	7	7	0	0
Uses tiered cost sharing	93	N/A	29	64
Copays	34	N/A	16	17
Coinsurance	0	N/A	0	0
Both	59	N/A	13	46
Coverage in the gap				
Generics	23	N/A	0	23
Generics and branded	5	N/A	0	5
None	72	N/A	29	36
Offers mail-order pharmacy services	96	7	27	62

Note: MA–PD (Medicare Advantage–Prescription Drug [plan]), PPO (preferred provider organization), PFFS (private fee for service), N/A (not applicable). Local plans (HMOs, PPOs, and PFFS plans) select individual counties in which they operate. Regional PPOs must provide Medicare services throughout a CMS-defined region that encompasses one or more states. Percentages are not weighted by plan enrollment. The MA–PDs described here exclude demonstration programs, 1876 cost plans, and plans offered in U.S. territories. Benefits labeled actuarially equivalent to Part D's standard benefit include what CMS calls "actuarially equivalent standard" and "basic alternative" benefits. Plans with "coverage in the gap" include some benefits in the range of beneficiary drug spending above the standard benefit's initial coverage limit and below its out-of-pocket threshold. Part D's defined standard benefit requires the enrollee to pay 100 percent coinsurance in this coverage gap.

Source: MedPAC analysis of CMS plan benefit package and landscape data.

- In addition to stand-alone PDPs, private health plans are offering 1,303 MA–PDs around the country. In order to enroll in an MA–PD, beneficiaries must elect to have their health care services (e.g., hospital and physician care) provided by the MA–PD. The vast majority of MA–PDs are offered at a local level; that is, availability varies depending on the county in which a beneficiary lives.

- The law allows MA–PDs to use 75 percent of the difference between an MA plan's benchmark payment and its bid for providing Parts A and B services (called rebate dollars) to supplement its package of benefits or lower its premium, including Part D premiums. For this reason, offerings through MA–PDs differ systematically from PDPs.

- A much larger proportion of MA–PDs (64 percent) provide enhanced benefits than do PDPs (43 percent). For 2006, 80 percent of all MA–PDs have no deductible compared with 58 percent of PDPs. They are also more likely to provide coverage within Part D's coverage gap: 23 percent of MA–PDs offer coverage of generic drugs, and another 5 percent of MA–PDs provide coverage of both generic and brand-name drugs. By comparison, 13 percent of PDPs offered generic coverage in the gap and 2 percent covered generic and brand name drugs.

Chart 11-11. Premiums and cost-sharing requirements among MA–PD drug benefits in 2006

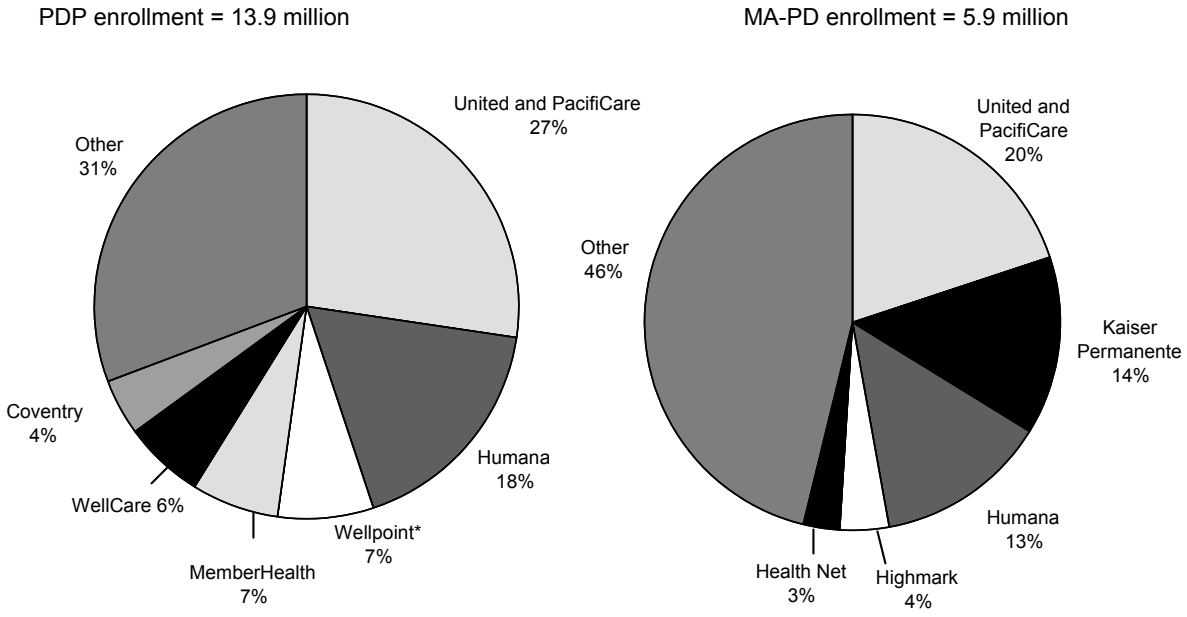
	Basic benefits		
	Defined Standard*	Actuarially equivalent	Enhanced benefits
Monthly drug premium			
Minimum	$0	$0	$0
Maximum	77	78	120
Median	23	24	0
Mean	25	21	16
Monthly total plan premium (including medical and drug premiums)			
Minimum	0	0	0
Maximum	202	179	260
Median	63	63	29
Mean	68	61	41
Deductible			
Minimum	250	0	0
Maximum	250	250	250
Median	250	0	0
Median cost sharing for:			
Plans with generic/brand tier structure			
Generic copay	N/A	5	7
Brand copay	N/A	30	30
Specialty tier coinsurance (where applicable)	N/A	25%	30%
Plans with generic/preferred brand/nonpreferred brand tier structure			
Generic copay	N/A	$5	$5
Preferred brand copay	N/A	29	28
Nonpreferred brand copay	N/A	55	50
Specialty tier coinsurance (where applicable)	N/A	25%	25%

Note: MA–PD (Medicare Advantage–Prescription Drug [plan]), N/A (not applicable). Values are not weighted by plan enrollment. The MA–PDs described here exclude demonstration programs, 1876 cost plans, and plans offered in U.S. territories. Cost sharing is for median cost sharing among plans that use tiered cost sharing before the initial coverage limit. Benefits labeled actuarially equivalent to Part D's standard benefit include actuarially equivalent standard and basic alternative benefits. *Part D's defined standard benefit has a $250 deductible (in 2006) and 25 percent coinsurance below an initial coverage limit of $2,250 (in 2006).

Source: MedPAC analysis of CMS plan benefit package and landscape data.

- Many Medicare Advantage organizations have applied some of their rebate dollars toward the premiums of enhanced plans. In 2006, the median monthly premium for an enhanced Medicare Advantage–Prescription Drug plan (MA–PD) is essentially zero. However, not every beneficiary has access to a zero-premium enhanced plan; availability depends on the county in which they live.
- In order to obtain MA–PD coverage, enrollees must pay the Part B premium and any other premium amount charged by their plan for regular medical services. The median combined MA–PD premiums for medical services and prescription drugs range from $29 to $63 per month.
- Median cost-sharing amounts are similar to those used by prescription drug plans. MA–PDs that use a generic/brand tier structure typically charge $5 to $7 to fill a generic prescription and $30 for brand name prescriptions. Plans that distinguish between preferred and nonpreferred brand name drugs have the following median copays: $5 for generics, $29 to $28 for preferred brand name drugs, and $55 to $50 for nonpreferred brand name drugs. Plans often charge 25 percent coinsurance for specialty and higher priced drugs.

Chart 11-12. Distribution of Part D enrollees by organization



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Data are as of April 27, 2006.
*Includes Blue Cross and Blue Shield New England Alliance, Blue Medicare Rx, and Unicare.

Source: MedPAC based on CMS enrollment data.

- As of late April 2006, Part D enrollment was concentrated among plans offered by a small number of parent organizations. Several of those organizations offer both stand-alone prescription drug plans (PDPs) and Medicare Advantage–Prescription Drug plans (MA–PDs). For example, United and PacifiCare (which merged recently) had 27 percent of the 13.9 million enrollees in PDPs and 20 percent of the 5.9 million enrollees in MA–PDs. Similarly, Humana had a considerable portion of both markets: 18 percent of PDP enrollees and 13 percent of MA–PD enrollees.

- As information on enrollment in specific Part D plans becomes available, the Commission will monitor those data to see how they affect plans' decisions to enter or exit the market.

Chart 11-13. Most Part D plans distinguish between preferred and nonpreferred brands and include specialty tiers

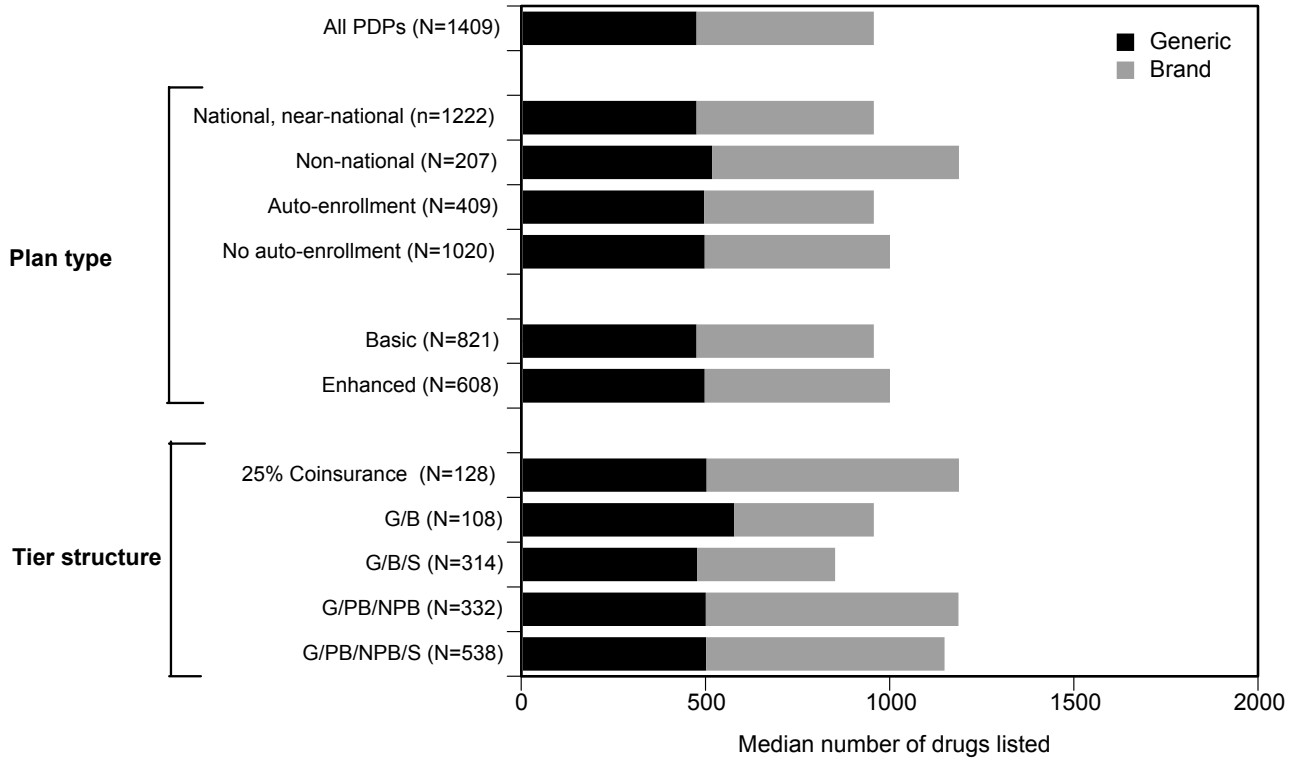
Plan characteristics	Distribution of plans by tier structures					
		Generic/brand		Generic/preferred brand/ nonpreferred brand		
	25% coinsurance, all tiers	Without specialty tier	With specialty tier	Without specialty tier	With specialty tier	Other
All Part D plans	8%	11%	15%	19%	45%	2%
All PDPs	9	8	22	23	38	1
National, near-national	5	8	21	25	40	0
Non-national	31	3	28	12	21	4
Auto-enrollment	23	2	33	9	33	1
No auto-enrollment	3	10	18	29	40	0
Basic	16	5	25	18	36	1
Enhanced	0	12	18	30	40	0
All MA–PDs	7	16	6	15	53	3
Local HMO	6	15	5	14	58	2
Local PPO	6	21	8	24	37	5
Regional PPO	29	8	15	10	38	0
PFFS	10	11	11	0	67	0
Basic	18	21	10	16	32	2
Enhanced	1	13	5	14	65	3

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), PPO (preferred provider organization), PFFS (private fee-for-service). The PDPs described here exclude plans offered in U.S. territories. The MA–PDs described here exclude demonstration programs, 1876 cost plans, and plans offered in U.S. territories. Auto-enrollment refers to PDPs that were eligible for automatically enrolled beneficiaries based on low-income status. Cost-sharing structures are for before the initial coverage limit of Part D. A specialty tier generally includes expensive products and unique drugs and biologicals, such as biotechnology drugs, for which enrollees may not appeal for lower cost-sharing amounts. Numbers may not sum to 100 percent due to rounding.

Source: National Opinion Research Center/Georgetown University analysis for MedPAC of formularies submitted to CMS for January 1, 2006.

- Most Part D formularies distinguish between preferred and nonpreferred brands. About a quarter of Part D plans distinguish only between brand name and generic drugs. Less than 10 percent of plans have 25 percent cost sharing for all covered drugs.
- 61 percent of PDPs and 68 percent of MA–PDs use the generic, preferred, and nonpreferred brand structure.
- PDPs with flat, 25 percent cost sharing were more likely to be non-national, basic, and qualify for auto-enrollment. Enhanced plans almost never use this structure.
- 60 percent of plans include a specialty tier in their formulary designs for expensive products and unique drugs and biologicals. Beneficiaries may not appeal the cost-sharing amount (generally limited to 25 percent) for drugs listed on a specialty tier.

Chart 11-14. Part D plans typically list about 1,000 drugs: PDPs

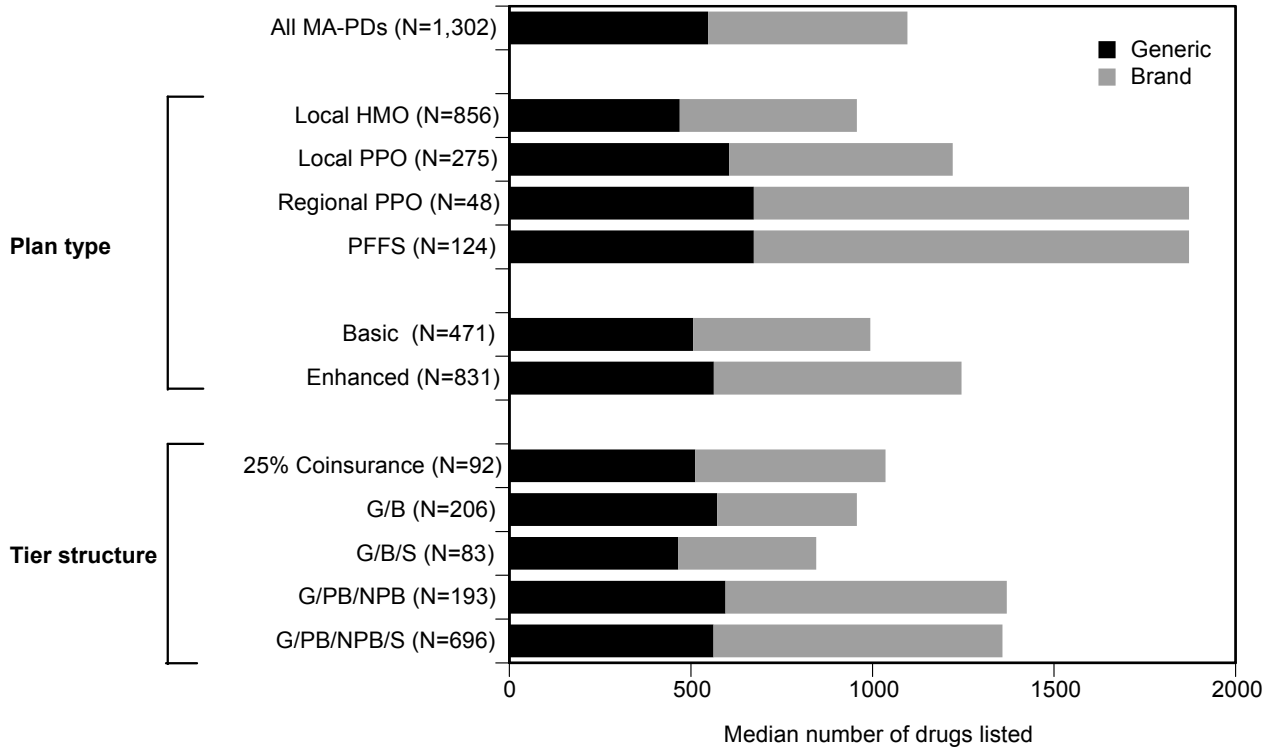


Note: PDP (prescription drug plan), G (generic), B (brand), PB (preferred brand), NPB (nonpreferred brand), S (specialty). Occasionally, plans list some generic drugs on brand tiers and vice versa. Plans with "other" tier structures are not displayed. The PDPs described here exclude plans offered in U.S. territories. A specialty tier generally includes expensive products and unique drugs and biologicals for which enrollees may not appeal for lower cost sharing.

Source: National Opinion Research Center/Georgetown University analysis for MedPAC of formularies submitted to CMS for January 1, 2006.

- Plan formularies in Part D typically list about 1,000 drugs. Among prescription drug plans (PDPs), the total number of drugs listed ranges from 618 drugs to 1,743 with a median of 957 drugs.
- Among PDPs, the non-national plans carry the largest formularies. Plans that are eligible for auto-enrollees typically list almost the same number of total drugs (and brand name drugs) as plans without auto-enrollment.
- Plans with only one brand-name tier typically list fewer drugs than plans with preferred and nonpreferred brand tiers on their formularies.
- The number of drugs on a plan's formulary does not necessarily represent beneficiary access to medications. Beneficiaries may access coverage for unlisted drugs through the plan's nonformulary exceptions process and may be denied coverage for listed drugs through prior authorization approval requirements.

Chart 11-15. Part D plans typically list about 1,000 drugs: MA–PDs



Note: MA–PD (Medicare Advantage–Prescription Drug [plan]), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service), G (generic), B (brand), PB (preferred brand), NPB (nonpreferred brand), S (specialty). Occasionally, plans list some generic drugs on brand tiers and vice versa. Plans with "other" tier structures are not displayed. The MA–PDs described here exclude demonstration programs, 1876 cost plans, and plans offered in U.S. territories. Cost-sharing are for before the initial coverage limit of Part D. A specialty tier generally includes expensive products and unique drugs and biologicals for which enrollees may not appeal for lower cost sharing.

Source: National Opinion Research Center/Georgetown University analysis for MedPAC of formularies submitted to CMS for January 1, 2006.

- Plan formularies in Part D typically list about 1,000 drugs. Among Medicare Advantage–Prescription Drug plans (MA–PDs), the total number of drugs listed ranges from 509 to 2,130, with a median of 1,096.

- Among MA–PDs, regional preferred provider organizations and private fee-for-service MA–PDs have the largest formularies, but these plans only represent 6 percent of the Part D landscape.

- Plans with only one brand-name tier typically list fewer drugs than plans with preferred and nonpreferred brand tiers on their formularies.

- The number of drugs on a plan's formulary does not necessarily represent beneficiary access to medications. Beneficiaries may access coverage for unlisted drugs through the plan's nonformulary exceptions process and may be denied coverage for listed drugs through prior authorization approval requirements.

Chart 11-16. The share of drugs listed in a therapeutic category depends on category size and regulation

	Median percent of drugs listed by selected therapeutic categories			
	Cholinesterase Inhibitors	Dyslipidemics	Opioid analgesics	Atypical antipsychotics*
Total drugs in category	4	20	61	6
Plan type:				
PDPs	75%	65%	39%	100%
MA–PDs	75	75	48	100

Note: PDP (prescription drug plan); MA–PD (Medicare Advantage prescription drug [plan]). Descriptions of therapeutic categories are given in parentheses: cholinesterase inhibitors (antidementia agents); dyslipidemics (anticholesterol agents); opioid analgesics (narcotic pain relievers); atypical antipsychotics (nonphenothiazines). Occasionally, plans list some generic drugs on brand tiers and vice versa. This table excludes plans offered in U.S. territories. The MA–PDs described here also exclude demonstration programs and 1876 cost plans.
*Under CMS regulation, plans are required to list all drugs in the atypical antipsychotic category.

Source: National Opinion Research Center/Georgetown University analysis for MedPAC of formularies submitted to CMS for January 1, 2006.

- In addition to regulatory coverage rules for certain therapeutic categories, the number of drugs Part D plans listed in a therapeutic class reflects the size of the class of drugs available in the marketplace.

- In classes with fewer drugs available, plans typically list a larger share of them. Conversely, when there are more drugs available in a given class, plans are able to negotiate better prices by listing only selected drugs on their formulary, particularly when there are overlapping products.

- For example, in a therapeutic class with only a small number of drugs, such as cholinesterase inhibitors (within the class of antidementia agents), plans typically list a higher share of available drugs in the market. But in classes where there are many drugs available in the market, such as opioid analgesics, plans typically list a much smaller share on their formularies.

- In classes for which CMS requires that plans cover all or substantially all drugs, plans predictably list a larger share of drugs. For example, in the class of atypical antipsychotics, both MA–PDs and PDPs typically list all of the available drugs.

Chart 11-17. Part D plans concentrate prior authorization in selected categories

Therapeutic category	Median percent of listed drugs subject to prior authorization, among plans that use it	
	PDPs	MA–PDs
All drugs	9%	9%
Atypical antipsychotics*	33	33
Dyslipidemics	13	17
Immune suppressants*	83	71
Metabolic bone disease agents	17	17
Molecular target inhibitors*	75	75
Opioid analgesics	12	9
Oral hypoglycemics	17	11
Proton pump inhibitors	50	75
Renin-angiotensins	2	4
Reuptake inhibitors*	5	5

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Descriptions of selected therapeutic categories are given in parentheses: atypical antipsychotics (antipsychotics, nonphenothiazines); dyslipidemics (anticholesterol agents); immune suppressants (rheumatoid arthritis agents); opioid analgesics (narcotic pain relievers); oral hypoglycemics (blood sugar level agents); proton pump inhibitors (stomach acid reducers); rennin-angiotensins (selected hypertension drugs); reuptake inhibitors (selected antidepressants). This table excludes plans offered in U.S. territories. The MA–PDs described here exclude demonstration programs and 1876 cost plans.
*Plans may only apply prior authorization to new-start enrollees—those not already taking a drug in these categories.

Source: National Opinion Research Center/Georgetown University analysis for MedPAC of formularies submitted to CMS for January 1, 2006.

- Most Part D plans apply drug utilization management tools to selected drugs. These tools include prior authorization (plans require pre-approval before coverage), step therapy (enrollees must try specified drugs before moving to other drugs), and quantity limits (plans limit the number of doses of a particular drug covered in a given time period).

- Plans use these tools for drugs that are expensive, potentially risky, subject to abuse, misuse, or experimental use, or to encourage use of lower-cost therapies.

- All prescription drug plans (PDPs) and almost all Medicare Advantage–Prescription Drug plans (MA–PDs) (98 percent) use prior authorization for at least one drug on their formularies. The median plan applies prior authorization to 9 percent of the drugs on its formulary. Step therapy is less commonly used among Part D plans and those that use it do so for a smaller proportion of drugs.

- In the class of proton pump inhibitors (PPIs), which have low-cost and over-the-counter drugs among the choices, PDPs and MA–PDs typically apply prior authorization to at least half of their listed PPIs.

- PDPs and MA–PDs that use prior authorization typically require it for most of the drugs in the immune suppressant category that includes expensive rheumatoid arthritis drugs. Plans are likely applying prior authorization restrictions in this category (and several other categories) to assist in determining whether the drugs should be covered under Part B instead of Part D.

Web links. Drugs

- Chapters 7 and 8 of the MedPAC June 2006 Report to the Congress provide information on the Medicare Part D program, as does MedPAC's Payment Basics series.

  http://www.medpac.gov/publications/congressional_reports/Jun06_Ch07.pdf
  http://www.medpac.gov/publications/congressional_reports/Jun06_Ch08.pdf
  http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_PartD.pdf

- Analysis of Medicare spending on oncology drugs can be found in MedPAC's January 2006 Report to the Congress: Effects of Medicare Payment Changes on Oncology Services.

  http://www.medpac.gov/publications/congressional_reports/Jan06_Oncology_mandated_report.pdf

- A Kaiser Family Foundation fact sheet, last updated in May 2006, provides information on the Medicare Part D benefit.

  http://www.kff.org/medicare/upload/7044-03-2.pdf

- A Kaiser Family Foundation analysis of formularies and other features of Medicare Part D plan.

  www.kff.org/medicare/upload/7489.pdf

- A Kaiser Family Foundation fact sheet on low-income assistance under the Medicare Part D benefit.

  www.kff.org/medicare/upload/7327.pdf

- A Kaiser Family Foundation fact sheet on enrollment in the Medicare Part D program.

  www.kff.org/medicare/upload/7466.pdf

- CMS information on Part D enrollment.

  www.cms.hhs.gov/prescriptiondrugcovgenin/02_Enrollmentdata.asp